EDWARD D. JONES & CO.

EMPLOYEE HEALTH AND WELFARE PROGRAM

PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION

As Amended And Restated
Effective January 1, 2025

*** * * IMPORTANT * * ***

Please read this Summary Plan Description in its entirety.

This document, together with any booklets or other descriptive material you have received from the Company, describes benefits available under the Plan and summarizes situations in which those benefits may be reduced, delayed, forfeited, or denied, as well as your rights and responsibilities and the procedures and deadlines for filing a claim or appeal and taking legal action against the Plan and its fiduciaries. This document and underlying benefit booklets describing the benefits under this document must be read together.

If you cannot find answers to your questions in this booklet or want more information about the Plan, please contact HRHELP@edwardjones.com or by calling 1-800-440-3060 or 314-515-1006.

EDWARD D. JONES & CO.

EMPLOYEE HEALTH AND WELFARE BENEFIT PROGRAM

PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION

INTRODUCTION

This document serves as the plan document and summary plan description (SPD) for the benefits provided to active associates under the Edward D. Jones & Co. Employee Health and Welfare Benefit Program (the "Plan"), which is sponsored by Edward D. Jones & Co., L.P. ("Edward Jones" or "Plan Sponsor"). For purposes of this SPD, the term "Company" will include the Plan Sponsor and any participating affiliate. This document describes the Plan as it applies to active associates, as in effect as of January 1, 2025. Prior to January 1, 2024, there were multiple documents representing the Plan, all of which are now combined together in this one plan document and summary plan description. This document supersedes all prior documents related to the welfare benefits offered by Edward Jones.

The benefits provided under the Plan are:

Core Benefits – Company Paid and provided automatically

- Basic Life Insurance coverage;
- Basic Accidental Death and Dismemberment coverage;
- Business Travel Accident Insurance;
- Employee Assistance Program (EAP);
- Long-Term Disability coverage;
    - For Home Office Associates (HOAs), Client Support Team professionals (CSTs), and Transitional Representatives (TRs)
    - For the first 12 months of employment for Financial Advisors (FAs), which includes selling general partners, financial advisor interns and trainees.
- Short-Term Disability coverage; and
- Wellness Programs.

The above listed benefits will collectively be referred to as "Core Benefits" throughout this document.

Optional Benefits – Shared Cost or associate Paid and must be elected by associates

- Medical coverage, including prescription drug;
- Dental coverage;
- Vision coverage;
- Health Care Flexible Spending Account;
- Limited Purpose Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account;
- Long-Term Disability coverage for General Partners and Financial Advisors
- Supplemental Accidental Death and Dismemberment coverage;
- Supplemental Life Insurance coverage;
- Supplemental Individual Disability Insurance; and
- Certain Voluntary Benefits.

The above listed benefits will collectively be referred to as "Optional Benefits" throughout this document.

This document governs the legal terms of the Plan and information relating to the election of benefits for the Core Benefits and Optional Benefits described above. The details of each underlying benefit is described in greater detail in separate summary plan descriptions or separate documents, summaries and benefit booklets.

This Plan is intended to qualify as a "cafeteria plan" within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the "Code"). It allows your employer to deduct any premiums and contributions you pay for your welfare benefits on a pre-tax basis (as applicable). These pre-tax contributions are excludable from your gross income for federal income tax purposes to the extent permitted by law. In some cases, your contributions may be paid on an after-tax basis. It is intended that all benefits provided under the Plan will be excluded from your gross income for federal income tax purposes pursuant to Code Sections including, but not limited to: 79, 105(b), 106 and 129, but this exclusion from income is not guaranteed by the Plan Sponsor or any participating affiliate. It is also intended that the health care flexible spending account should qualify as a limited excepted benefit under Code Section 9831.

The Plan is intended to satisfy all other applicable requirements of the Code and the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") and the regulations promulgated thereunder. This Plan is also intended to satisfy those requirements of ERISA, which are applicable to employee welfare plans. Nothing in this Plan shall be construed as requiring compliance with Code or ERISA provisions that do not otherwise apply to a particular benefit.

This document serves two important functions related to the Plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law applying to certain employee benefit plans:

- First, ERISA requires that employers provide eligible associates with a description of the various benefit plans it maintains. Such information is to be included in an SPD for each plan. This document, together with any booklets or other descriptive material you have received from the Company, constitutes the SPD for the Plan.

- Second, ERISA requires that employee benefit plans be maintained pursuant to a written plan document. This document also constitutes the written plan document under ERISA.

IMPORTANT: This description and the booklets, certificates and other descriptive material provided to you by the Company and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. There may be other Plan materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed provisions. Every effort has been made to ensure that all of these materials contain a consistent description of the Plan's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Plan. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the Company and does not give you the right to be retained in the employment of the Company. No one speaking on behalf of the Plan or the Plan Sponsor can alter the terms of the Plan. You and your beneficiaries may obtain copies of the Plan and its related documents or examine these documents by contacting the Plan Administrator at the number and address set forth in the GENERAL INFORMATION section of this document. Although Edward Jones intends to maintain the benefits described in this document for an indefinite period of time, Edward Jones retains the right to amend or terminate any of the benefits described in this document as it relates to any associate, dependent, beneficiary or subclass thereof in whole or in part at any time and for any reason.

GENERAL INFORMATION

1.	Plan Name:	Edward D. Jones & Co. Employee Health and Welfare Program
2.	Employer/Plan Sponsor	Edward D. Jones & Co., L.P. d/b/a Edward Jones 12555 Manchester Road St. Louis, MO 63131 Phone: (314) 515-2000
	Plan Administrator:	Benefits Administrative Committee c/o Edward D. Jones & Co., L.P. d/b/a Edward Jones 12555 Manchester Road St. Louis, MO 63131
3.	IRS Employer Identification Number:	43-0345811
4.	Plan Number:	501
5.	Plan Types:	The Plan is a welfare benefit plan providing the following types of benefits: (a) medical (including prescription drug); (b) dental; (c) vision; (d) life insurance; (e) accidental death and dismemberment; (f) long-term disability; (g) short-term disability; (h) employee assistance; (i) health care flexible spending account; (j) dependent care flexible spending account; (k) health savings account; (l) certain voluntary benefits; and (m) wellness programs. The benefits described in items (a), (b), (c), (h), (i), (l) and (m) are provided under a "group health plan" within the meaning of ERISA.
6.	Type of Administration:	The Plan Administrator administers the Plan with assistance from third party providers of insurance and administration services.
7.	Agent for the Service of Legal Process:	Assistant General Counsel Edward D. Jones & Co., L.P.12555 Manchester Rd. St. Louis, MO 63131
8.	Plan Year:	2025 Calendar Year
9.	Funding:	Benefits under the program are paid through a combination of insurance and directly from the general assets of the as shown in Appendix A.

WHO PARTICIPATES IN THE PLAN

Associate Eligibility Medical Benefits (including Prescription Drug Benefits), Health Care Flexible Spending Accounts, and Voluntary Benefits

You will be considered eligible for the Plan's medical coverage, health care flexible spending accounts and voluntary benefits if you are an associate of Company and you worked, on average, at least 30 Hours of Service (defined below) per week over the course of a measurement period that takes place before the Plan Year begins. This measurement period is known officially as the Standard Measurement Period; you may also hear it described informally as the "look-back" method.

Associates who meet the "Rule of 70" may be eligible for medical coverage (referred to as the "Long Service Plan"). Under the Rule of 70, associates are eligible for medical benefits if:

- They are at least 50 years old at the time of retirement or termination; and
- Their age at that time, added to their active working years of service with the Company equals at least 70.

Standard Measurement Period. Edward Jones will calculate the hours you worked during this measurement period to determine whether you will be considered full-time and eligible for medical benefits coverage during the next Plan Year. Alternatively, if you are a relatively recent hire, your status as an eligible associate will be based on the rules for "New Associate," as described in greater detail below.

For purposes of this analysis, an "Hour of Service" means an hour for which you are paid, or entitled to payment, for the performance of duties for the firm. An "Hour of Service" also includes an hour for which you are paid or entitled to payment by the Company for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Before reviewing the eligibility rules below, consult the following chart to determine which method will be used to determine your eligibility for medical benefits:

Hire Date	Eligibility Rules
Before October 11, 2023	Standard Measurement Period for 2025 and beyond
On or after October 11, 2023, but before October 9, 2024	• "New Associate" method for 2024 • Standard Measurement Period for 2025 and beyond
On or after October 11, 2023	• "New Associate" method for 2024 • Standard Measurement period for 2025 and beyond

To determine whether you are eligible for medical benefits in 2025, Edward Jones will measure your Hours of Service worked from October 11, 2023, through October 9, 2024 (the Standard Measurement Period). In addition, any unpaid FMLA, USERRA, and/or jury duty leaves will not count against you. Edward Jones will consider you to have been at work during these three special types of leave.

Standard Stability Period. If you averaged at least 30 Hours of Service per week during the Standard Measurement Period, you will be eligible to participate in the Plan's medical benefits for a "Standard Stability Period." Your Standard Stability Period means the subsequent Plan Year. You will be eligible for medical benefits for the entire Standard Stability Period (i.e., the entire Plan Year), even if your hours or wages decrease during the Standard Stability Period, so long as you remain an associate and continue to make any required contributions toward your coverage.

If you have not been with Edward Jones for the full duration of this Standard Measurement Period, you are considered a "New Associate." See below for information about the special eligibility rules for "New Associates."

Periods with No Hours of Service. If you experience a period of 13 consecutive weeks (or longer) without working an Hour of Service – either because you terminate employment or because you are absent for some other reason – you will have a "break in service." This means that you will be treated as a New Associate to the extent permitted by law. There are special eligibility rules for New Associate, which are explained below.

In most cases, you will not work an Hour of Service during an unpaid leave of absence. However, if your time away from work is paid leave, you will be considered to have worked an "Hour of Service" for each paid hour.

New Associate Method. You are considered a "New Associate" for purposes of eligibility for the Plan's medical coverage benefits if you did not work for the entire Standard Measurement Period before the 2023 Plan year. When you are hired as a New Associate, Edward Jones will classify you as either New Full-Time, Variable Hour, Part-time, or Seasonal for purposes of eligibility for the Plan's medical coverage benefits.

- **New Full-Time:** If Edward Jones reasonably expects you to work at least 30 hours per week on average, you will be classified as New Full-Time, and you will be eligible for medical benefits as of the first of the month following 30 days after your date of hire. Your status as an eligible full-time associate will be determined based on whether you are expected to work 30 or more hours per month during a particular month. Once you have worked a full 12-month Standard Measurement Period, your eligibility for the following Plan Year will be measured using the look-back periods described above.

- **New Variable Hour/Part-time/Seasonal Associate:** If Edward Jones classifies you as a New Variable Hour Associate, a New Part-time Associate, or a New Seasonal Associate, you will not be offered medical coverage immediately. Instead, your hours will be tracked over an Initial Measurement Period to determine whether you average over 30 hours of service a week during that period. Your Initial Measurement Period will begin on your date of hire and will end twelve months later.

    - If you average at least 30 Hours of Service per week during the Initial Measurement Period, you will be notified that you are eligible for coverage for a period of time following the Initial Measurement Period called the "Initial Stability Period." You will be given an opportunity to elect medical coverage at that time. If elected, your medical coverage will begin no later than the first of the month following 13 full calendar months after your date of hire.

    - If you average less than 30 Hours of Service during the Initial Measurement Period, you will not be eligible for medical coverage during the Initial Stability Period.

If you are hired as a New Variable Hour, Seasonal, or Part-time Associates, but during the Initial Measurement Period you are moved to a Full-Time job classification, you will be eligible for coverage on the first day of the month following one month after the job classification change. If you would be

eligible sooner during an Initial Stability Period, you will be eligible on the first day of the Initial Stability Period. The determination of whether you are a New Variable Hour, Seasonal, or Part-Time Associate will be made in accordance with the rules established by the Internal Revenue Service.

Compliance with Hawaii Law. In compliance with Hawaii state law, associates in Hawaii who work 20 hours or more per week for four consecutive weeks shall be offered medical coverage, regardless of whether or not they satisfy the look-back method described above. The cost and type of coverage shall comply with the requirements of the Hawaii Prepaid Health Care Act.

Long Service Plan

Associates who meet the "Rule of 70" may be eligible for medical coverage under the Long Service Plan. The Long Service Plan is described in the Continuation Coverage Under Long Service Plan section of the Plan Document.

Associate Eligibility for Dental, Vision, Short-term Disability, Long-term Disability, Accident Death and Dismemberment, Business Travel Accident Insurance, Life Insurance, and Dependent Care Flexible Spending Account

Eligibility for life insurance (as described below) and medical benefits (as described above) are in addition to the eligibility described here. In general, you are eligible to participate in benefits offered through the Plan if you are:

- an employee of Edward D. Jones & Co., L.P., Edward Jones Trust Company, or an affiliate of Edward D. Jones & Co., L.P. or you are a general or limited partner of The Jones Financial Companies, L.L.L.P., (collectively referred to as Edward Jones associates);
- classified as full-time, work at least 35 hours per week; and
- one of the following:
    - Home Office Associates (HOA), Client Support Team professionals (CST), and Transitional Representatives (TR), or
    - General Partners (GP), which includes subordinated limited partners, Service Partners* (SP), or
    - Financial Advisors (FA), which includes selling general partners, financial advisor interns and trainees. In addition, any full-time associate living and temporarily working full-time for Edward Jones or its affiliates outside the U.S. is also eligible to participate in the Plan, so long as they remain on the U.S. payroll.

*For purposes of the Plan and the Plan documents, the term Service Partner includes individuals who are both Service Partners of the Jones Financial Companies, L.L.L.P. and Joint Venture Financial Advisors within the meaning of the Partnership Agreement. Due to current IRS tax regulations, SPs and GPs are not eligible to participate in FSAs.

Additional Eligibility for Life Insurance

All full-time active associates who work at least 35 hours per week or are classified as full-time by Edward Jones are eligible for life insurance coverage if they are citizens or legal residents of the United States working in the United States, its territories or protectorates, or expatriates and third-country nationals; excluding:

1. temporary, leased or seasonal associates; and

2. any associate living or working in a country:

    a. subject to a sanctions program administered by the United States Treasury Office of Foreign Asset Control; or

    b. not meeting our underwriting criteria.

The following individuals are not eligible to participate: (i) employees who are members of a collective bargaining unit (unless a bargaining agreement so provides), (ii) temporary employees, (iii) seasonal employees, (iv) leased employees, and (v) independent contractors and other persons who are not treated by the Company as employees for purposes of withholding federal employment taxes, regardless of any contrary governmental or judicial determination relating to such employment status or tax withholding.

Dependents

You may be able to enroll your eligible dependents in some of the plans provided under the Plan. Examples of eligible dependents include:

- your legal spouse (i.e., an individual of the same- or opposite-sex as you and who may be claimed as your spouse for federal income tax purposes);
- your domestic partner;
- your natural children;
- your stepchildren who live with you and/or your spouse in a legal parent-child relationship;
- your adopted children, or an individual who is lawfully placed with you either for legal adoption or for foster care by an authorized placement agency or court order;
- a child for whom you have legal custody or guardianship, who depends on you for support and who you can claim as an exemption on your Federal income tax return.
- the natural children of your domestic partner, stepchildren of your domestic partner living with your domestic partner in a legal parent-child relationship, a child who is lawfully placed with your domestic partner either for legal adoption or for foster care by an authorized placement agency or court order, or any other children for whom your domestic partner has legal custody or guardianship, who depend on your domestic partner for support and who can be claimed as exemptions on his or her federal income tax return.

Your spouse must be under age 70 to enroll for Family AD&D coverage.

Common-law spouses are not eligible for coverage as “spouses.” However, common-law spouses may be eligible if they are a domestic partner.

Note: You cannot be covered as both an associate and a dependent. If you qualify as both, you can only be covered as an associate. If both parents work for the Company, only one parent can cover the children.

You may be required to provide documentation or proof of dependent eligibility to enroll a dependent in coverage or to continue dependent coverage under the Plan from time to time.

Unless otherwise stated in a fully insured benefit subject to state law, eligibility requirements for your spouse, domestic partner, and/or other dependent(s) are as follows:

Medical Benefits

- **Spouse** – Your lawful spouse is eligible to participate in these benefits under the Plan.

- **Domestic Partner** – Your same-sex or opposite-sex domestic partner is eligible to participate in these benefits under the Plan. You will be required to submit an "Affidavit of Domestic

Partnership" to the Plan.

- A domestic partner includes the following:

  - You and your partner are at least eighteen (18) years of age and mentally competent to consent to contract; and
  - You and your partner have had an exclusive relationship for at least one year and intend it to last indefinitely; and
  - You and your partner have shared the same principal place of residence with each other for at least one year and intend to do so indefinitely; and
  - You and your partner are not related by blood to a degree of closeness which would prohibit marriage under the laws of the state in which you reside;
  - Neither you nor your partner are legally married to someone else and are not the domestic partner of someone else; and
  - You and your partner are responsible for each other's common welfare and financial obligations. You and your partner are liable to third parties for any obligations incurred by each other and will continue to be so liable during the period that your partner is covered under the Plan.

Imputed Income for Domestic Partners and the Domestic Partner's Dependent Child(ren)

- The amount of your contribution to provide health benefits for a domestic partner and children of a domestic partner will be the same as for a spouse and his or her children. However, the Internal Revenue Code treats spouses and children through marriage differently with respect to health benefits. The cost of coverage for a spouse and stepchildren is automatically exempt from taxes, but for a person who is not a spouse or a stepchild through marriage, a payment for health benefit coverage is not exempt from tax unless the person is a "dependent" as defined in the Internal Revenue Code.

- If your domestic partner and his or her children meet certain requirements for tax purposes, you may provide the Plan with an "Affidavit of Dependency Status" to that effect to gain the benefit of tax-favored benefit coverage. If they qualify as dependents for tax purposes, the cost of coverage under the Plan will be deducted from your pay on a pre-tax basis and no additional income will be imputed to you.

- If your domestic partner and his or her children are not your dependents for tax purposes, the value of any health coverage provided to your domestic partner and his or her child(ren) is imputed as income to you (paid for on an after-tax basis). Your contributions for health coverage will continue to be made on a pre-tax basis; however, you will see additional income imputed to you on your paystub.

- **Children** – Dependent children include you or your spouse/domestic partner's:

  - biological children;
  - legally adopted children;
  - stepchildren;
  - foster children;
  - a child of a Domestic Partner;
  - children placed in your home for adoption; or
  - children for whom you or your spouse is required to provide health care pursuant to a Qualified Medical Child Support Order.

A child described above will be considered an eligible dependent child for purposes of the Plan if the child meets the requirements set forth in the applicable benefits booklet for the coverage elected and is:

- under age 26, regardless of marital status, student status or support; or
- age 26 or older, unmarried, became physically or mentally disabled prior to age 26, and relies on you or your spouse for support or care.

The Company may require proof of age, marriage, domestic partnership, legal guardianship, disability, etc., in order to enroll a dependent.

In the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (1) who are divorced or legally separated under a decree of divorce or separate maintenance; (2) who are separated under a written separation agreement; or (3) who live apart at all times during the last six months of the year, and where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents, regardless of the child's place of residence or the amount of support provided by either parent. Contact your tax advisor or refer to IRS Publication 502 for more information.

By enrolling your dependents under the Plan, you are certifying that the above eligibility requirements have been met. There may be adverse tax consequences to you if it is determined that benefits were paid on behalf of an ineligible dependent. In addition, if you intentionally enroll, or fail to remove, an ineligible dependent, you may be required to repay any benefits paid to such individual and you may be subject to disciplinary action.

Health Care Flexible Spending Account

Individuals who are enrolled in the high deductible health plan with the Health Savings Account are not eligible to participate in the Health Care Flexible Spending Account. The health care FSA can be used to reimburse medical expenses incurred by the following individuals:

- you,
- your spouse,
- your child, stepchild legally adopted child (or a child placed with you for adoption) or foster child who has not attained age 27 as of the close of the year, and
- your tax dependents in accordance with Section 152 of the Internal Revenue Code.

Limited Purpose Flexible Spending Account

Individuals who are enrolled in the high deductible health plan with a Health Savings Account are eligible to participate in the Limited Purpose Flexible Spending Account. The Limited Purpose Flexible Spending Account reimburses employees for limited scope dental and vision benefits only and can be used to reimburse eligible medical expenses incurred by the following individuals:

- you,
- your spouse,
- your child, stepchild legally adopted child (or a child placed with you for adoption) or foster child who has not attained age 27 as of the close of the year, and
- your tax dependents in accordance with Section 152 of the Internal Revenue Code.

Dependent Care Flexible Spending Account

The dependent care FSA can be used to reimburse day care expenses for any of the following individuals:

- your dependent child who is under age 13;
- spouse or other tax dependent.

Dental, Vision, Life Insurance, and AD&D Insurance

For the Dental and Vision, benefits provided under the Plan, eligible children include:

- unmarried children until they reach age 19.
- An eligible child may continue to be covered until they reach age 23, provided they are a full-time student (minimum of 12 hours per semester, or final semester prior to attaining a degree).

You will certify your child's student status as you enroll in benefits. It is your responsibility to notify the Edward Jones Benefits Department if your child(ren) over the age of 19 is no longer a full-time student.

When a child's status changes, coverage will end on the last day of the pay period for which you are responsible for paying the dependent coverage cost. Your child must live with you for more than half of the year to be considered an eligible dependent. Exceptions apply, in certain cases, including children of divorced or separated parents or temporary absences.

Full-time students are presumed to live with you, even if they are attending school away from home. Your child must also not provide more than one-half of his/her own support for the year.

For the Life Insurance and AD&D benefits provided under the Plan, eligible children include unmarried children who are 1) under the age of 26 and 2) supported by you.

A child under the Life Insurance and AD&D benefits is defined as your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Domestic Partner), a child for whom You are the legally appointed guardian who resides with you, a child you resides with and is fully supported by you, a foster child who resides with you, or a child for whom you have a court order to provide coverage who resides with you.

Eligible Incapacitated Children. If your unmarried child is above the age limits, he or she may be added to the plan, or you may continue coverage if he or she:

- is unable to support himself or herself due to developmental disability or a physical incapacity as outlined by our provider, and
- depends on you for support and maintenance or depends on other care providers for lifetime care and supervision.

Evidence of Incapacitation. For dental and vision coverage, you must provide proof of your child's incapacity to the Edward Jones Benefits Department within 31 days after your child reaches age 19 (or age 22 if your child is a full-time student). For medical coverage, you must provide proof of your child’s incapacity to the Edward Jones Benefits Department within 31 days after he or she reaches age 26. The claims administrator may ask for proof of incapacity and dependency at any reasonable time. Proof must be provided within 60 days, or coverage may be terminated as of the date the plan requests proof.

For a more complete description of the eligibility provisions for each Core Benefit or Optional Benefit

provided under the Plan, please refer to the separate descriptive booklets which you have received from the Company and any applicable insurance companies.

HOW THE PLAN WORKS

The Plan has been established to provide eligible employees with access to the Core Benefits described in the "Introduction" section and a choice between the Optional Benefits provided by the Company. The special design of the Plan enables participants to select benefits that best meet their individual needs. The Plan is intended to qualify as a "medical care plan" under Code Section 105 and 106 and is to be interpreted in a manner consistent with the requirements of Code Sections 105 and 106. It is intended that the value of coverage be excluded from the participant's income under application Code Sections, including but not limited to Sections 79, 105(b),106 and 129.

The Selection Process

Eligible employees are automatically covered by the following Core benefits at no cost to the eligible employee:

- Basic Life Insurance coverage;
- Basic Accidental Death and Dismemberment coverage;
- Business Travel Accident Insurance;
- Long-Term Disability coverage;
    - For Home Office Associates (HOAs), Client Support Team professionals (CSTs), and Transitional Representatives (TRs),
    - For the first 12 months of employment for Financial Advisors (FAs), which includes selling general partners, financial advisor interns and trainees.
- Short-Term Disability coverage;
- Employee Assistance Program; and
- Wellness Programs.

There is no election to be made with respect to Core Benefits. In addition to Core Benefits, Plan participants can also select from among Optional Benefits. The cost for Optional Benefits is shared between the eligible employee and the Company. Optional Benefits include:

- Medical coverage, including prescription drug;
- Dental coverage;
- Vision coverage;
- Health Care Flexible Spending Account;
- Limited Purpose Health Flexible Spending Account;
- Dependent Care Flexible Spending Account;
- Long-Term Disability for General Partners (GPs) and Financial Advisors (FAs)
- Supplemental Accidental Death and Dismemberment coverage;
- Supplemental Life Insurance coverage;
- Supplemental Individual Disability Insurance; and
- Certain Voluntary Benefits.

*Note that if you enroll in the high-deductible health plan option, you may be able to establish and contribute to a health savings account (HSA).

When to Enroll

Medical, Dental, Vision, Health Care Flexible Spending Account, Limited Purpose Health Flexible Spending Account and Dependent Care Flexible Spending Account, and Certain Voluntary Benefits

If you or your dependents want any of the above-stated plans, you must enroll within 31 calendar days of the date you first become eligible to enroll.

If you do not enroll within 31 calendar days, you will not be eligible for Medical, Dental, Vison, Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Dependent Care Flexible Spending Account, and Certain Voluntary Benefits coverage until the next open enrollment period, unless you experience a Life Event which allows an election change during a Plan Year. Generally, unless otherwise communicated if you were a participant in the Plan during the prior Plan Year and you fail to make a new election during an open enrollment period, you will continue to receive the same benefits that were in effect under your election for the prior Plan Year and your regular compensation will be appropriately reduced, except for any Flexible Spending Account and Health Savings Account elections, as applicable.

Long-Term Disability, Supplemental Life Insurance, Supplemental Accidental Death and Dismemberment

If you or your dependents want any of the above-stated plans, you may apply for coverage at any time unless provided otherwise, in the following after-tax optional benefits:

- Long-Term Disability for General Partners (GPs) and Financial Advisors (FAs)
- Supplemental Accidental Death and Dismemberment coverage;
- Supplemental Life Insurance coverage;

Supplemental Individual Disability Insurance

During each yearly open enrollment period (usually during October/November), you must log on to the Edward Jones benefits enrollment site and/or contact Edward Jones Benefits Department, to change Optional Benefits. A newly hired employee will receive information outlining the process and timeline for enrolling in the Plan. Please note: Unless otherwise communicated, if you do not make a new election during the annual open enrollment period, you will be deemed to have elected to keep the same coverage election (including an election of no coverage) in force for the coming year. However, in the case of contribution elections for the Flexible Spending Accounts (both health care and dependent care) and for your Health Savings Account (HSA)*, if you fail to make an election, you will not have FSA and/or HSA elections in effect for the upcoming plan year.

Your regular compensation will be reduced by the amount of the premiums and other charges that correspond to the participant cost of the pre-tax benefits you choose. One exception to this is the premium for supplemental life insurance and supplemental AD&D, which is deducted on an after-tax basis.

The advantage of paying for benefits by reducing your compensation is that amounts so paid will not be subject to federal income tax or FICA. You may, therefore, have more disposable income than you would have had if you purchased your benefits with money that had already been taxed. This reduction of your compensation, however, may not apply for local tax purposes, depending on local tax law. Because your contributions are not subject to Social Security taxes, you may have a slightly reduced Social Security retirement or disability benefit. This will only happen if your taxable wages after pre-tax contributions are less than the Social Security taxable wage base. However, the current tax advantages should more than offset any reduction in your Social Security benefit.

Example: If you purchased medical coverage for $100 each month from your take home pay (after-tax pay), you would have to earn $156 in gross (pre-tax) pay, assuming federal income tax of 28% and FICA of 7.65%. If you purchased the same coverage with pre-tax dollars, you would only have to earn $100 to pay for the insurance.

***** *An HSA is not a Firm sponsored benefit or an ERISA plan. Eligibility requirements apply and contribution limits are set by the IRS.*

If You Make No Benefit Election

To participate in the Plan, you generally must choose the Optional Benefits you want and complete and submit an election. If you are a newly eligible employee and do not make any election, you will be defaulted into Core Benefits with no Optional Benefits coverage for the Plan Year and will not be able to enroll in Optional Benefits until the next open enrollment period, unless you experience a Life Event which allows an election change during a Plan Year. Generally, unless otherwise communicated, if you were a participant in the Plan during the prior Plan Year and you fail to make a new election during an open enrollment period, you will continue to receive the same benefits that were in effect under your election for the prior Plan Year and your regular compensation will be appropriately reduced, except for any Flexible Spending Account and Health Savings Account elections, as applicable.

Notwithstanding the foregoing, Client Support Team professionals (CSTs) and Home Office Associates (HOAs) and Transitional Representatives (TRs) may not waive (decline) firm-provided benefits including Basic Life Insurance, Basic AD&D insurance, Business Travel Accident Insurance, EAP, and Long-Term Disability and Short-Term Disability insurance. Financial Advisors may not waive firm-provided Basic Life Insurance, Basic AD&D insurance or Long-Term Disability (LTD) insurance (applies only to new FAs with less than one year of service). FAs may waive LTD after one year of service and may waive the FA Survivor Benefit program. If you voluntarily waive (decline) the FA Survivor Benefit program, you may not request enrollment in the program at a later date.

Changes To Your Elections During The Plan Year

Generally, you may not make changes to your coverage selections during the Plan Year. (This restriction is due to requirements under federal law.) However, you may make a change to an election that is on account of and consistent with one of the events described below. If you have a change in family or work status – sometimes referred to as a "Life Event" – or under certain other circumstances, you may join, re-join, opt out, increase or decrease coverage (e.g., change from employee to family coverage or vice versa) if you notify the Company within 31 days of the change. The following list describes circumstances that may permit you to make a mid-year election change.

Life Events. If one or more of the following Life Events occur, you may revoke your old election during the year and make a new election, provided that both the revocation and new election are on account of and correspond with the Life Event (as described below). Those occurrences that qualify as Life Events include the events described below, as well as any other events that the Plan Administrator determines are permitted under applicable regulations:

Change in Marital Status – a change in your legal marital status (such as marriage, annulment, divorce or death of your spouse),

Change in Number of Dependents – a change in the number of your dependents (such as the birth of child, adoption or placement for adoption of a dependent, or death of a dependent),

Change in Employment Status – any of the following events that change the employment status of you, your spouse or your dependent that affects benefit eligibility under an employee benefit plan (including this Plan) of you, your spouse or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a commencement of or return from an unpaid leave of absence, a change in worksite, switching between salaried and hourly-paid or part-time and full-time, incurring a reduction or increase in hours of employment, or any other similar change that makes the individual become (or cease to be) eligible for a particular benefit under the Plan,

Change in Dependent Eligibility – an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit, such as attainment of age, student status, or any similar circumstance, or

Change in Residence – a change in your place of residence.

If a Life Event occurs, you must inform the Plan Administrator within 31* days of the Life Event. The Plan Administrator will send you the form(s) necessary to report a change or direct you to the online portal where you can report your Life Event. Except in the circumstances noted below, your coverage change will be effective on the first day of the pay period following your election change request for Home Office (HOA) Client Support Team (CST), and Transitional Rep (TR) roles, 1st of the monthly following your election change request for Financial Advisor (FA) and Principal (GP) roles. Notwithstanding the foregoing:

- If the Life Event is birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

- If you spouse and dependents die, your election to disenroll your deceased spouse or dependents under the Plan will be effective on the date of the event, provided you timely provide notification of the event.

*90 days for birth, adoption or placement for adoption.

If you wish to change your election based on a Life Event, you must establish that the revocation of your existing election and the new election are on account of and correspond with the Life Event. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Life Event, as described in applicable regulations. As a general rule, a desired election change will be found to be consistent with a Life Event if the event affects coverage eligibility and the change responds to that election change. (This means, for example, that you may be limited to adding or dropping dependents, rather than changing coverage options.) In addition, you must also satisfy the following specific requirements in order to alter your election based on the Life Event:

Life Event Involving Loss of Dependent Eligibility – A special rule governs which type of election change is consistent with the Life Event. For a Life Event involving (a) divorce, annulment or legal separation from your spouse, (b) the death of your spouse or your dependent or (c) your dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel coverage for any individual other than a person losing eligibility as a result of the event would fail to correspond with that Life Event.

Life Event Involving Coverage Eligibility Under Another Plan – For a Life Event in which you, your spouse or your dependent gain eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in your, your spouse's or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Life Event only if coverage for that individual becomes effective or is increased under the other employer's plan.

Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), or employer contributions for that coverage were terminated, you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage, if you do so within 31 days after the loss of coverage or employer contributions. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or one of your dependents (i) loses eligibility for coverage under Medicaid or a state children's health insurance program ("CHIP"), or (ii) become eligible for a premium assistance subsidy under a state CHIP, you may enroll yourself or your dependent(s) (whomever was affected by the eligibility loss or premium subsidy) for medical coverage under the Plan if you do so within 31 days of the loss of coverage or the eligibility for premium subsidy.

Certain Judgments and Orders. If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child. The child must otherwise meet the Plan's definition of a dependent (e.g., the age requirement). If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

Entitlement to Medicare or Medicaid. If special enrollment rights do not apply and you, your spouse or a dependent actually enroll in Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your spouse or a dependent who has been enrolled in Medicare or Medicaid loses eligibility for the same, you may, subject to the terms of the underlying plan, elect to begin or increase that person's health coverage.

Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan will be significantly curtailed during the Plan Year, you may revoke your election and elect coverage under another plan option that provides similar coverage. You may also revoke your election if there is a significant curtailment that amounts to a loss of coverage (e.g., an HMO ceases to be available) and there is no other benefit option that provides similar coverage. However, if there is a significant curtailment that does not amount to a loss of coverage (e.g., an increase in deductibles or co-payments), you may not drop your coverage but only switch to a similar coverage. Also, if during the Plan Year the Plan adds or eliminates a benefit option, you may elect the newly added option or elect another benefit option (when a Plan option has been eliminated). Additionally, you may make an election change when there is a significant improvement in coverage provided under an existing benefit option. Finally, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's or dependent's employer, so long as: (a) his or her employer's plan permits its participants to make an election change permitted under applicable regulations; or (b) the plan year of the other plan is other than January 1 – December 31.

Except as provided in the last two items above, in no event are you permitted to change health insurance providers during the Plan Year. Such a change may take place only during the annual open enrollment period prior to each Plan Year.

BENEFITS

This section summarizes the types of benefits that are available to you. For a more complete description of the benefits available under each coverage option, please refer to the separate descriptive booklets which you have received from the Company and insurance companies.

Medical Option

As a participant in the Plan you may elect to participate in medical coverage including prescription drug coverage. Based upon various factors (such as where you live or whether you are a full-time or part-time employee), you will be eligible for either the self-insured medical options or a fully insured medical options offered under the Plan. The prescription drug coverage occurs automatically upon enrollment in a medical option. The monthly costs and the description of your medical and prescription drug options are described in the annual or new employee enrollment packages, including any other underlying documents to the medical and prescription drug benefit. Your contributions will be made on a pre-tax basis.* The Company will inform you during each open enrollment period concerning the cost of coverage and the various levels of coverage that are available, including what benefits options you are eligible to choose from during the enrollment process.

*See the Domestic Partner information above regarding taxation.

You may be offered the opportunity to establish a health savings account (HSA) related to participation in a high-deductible health plan (HDHP) option under the Plan. An HSA is an individual trust or custodial account, separately established and maintained by you with a qualified trustee/custodian. You may elect to contribute funds to your HSA on a pre-tax basis up to the legally permissible limit.

Decisions on Health Care. The Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The Plan and any applicable insurance contracts contain rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. The covered individual in accordance with the Plan's claims procedure may dispute any decision with respect to the coverage of a particular health care expense. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the Company will have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of covered expenses, if applicable.

Special Rules Related to Pregnancy and Childbirth. The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance issuer (including an HMO) for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Special Coverages Required by the Women's Health and Cancer Rights Act. The Women's Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

These services will be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services are subject to any applicable deductibles and coinsurance amounts.

Medicare Part D Prescription Drug Coverage. The Plan Administrator has determined that the prescription drug coverage offered as part of the medical benefits is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered creditable coverage. Because this coverage is, on average at least as good as standard Medicare prescription drug coverage. Employees can keep this coverage and not pay a higher premium (a penalty) if they later decide to join a Medicare drug plan. The Plan Administrator will distribute certificates of creditable coverage to employees upon participation in this Plan, during each subsequent open enrollment period, and any time the prescription drug coverage ends or is no longer considered creditable.

Mental Health Parity Act of 1996. This Plan will comply with the Mental Health Parity Act of 1996 and regulations promulgated thereunder, with respect to parity between mental health and substance use disorder benefits and medical and surgical benefits provided under this Plan.

Genetic Information Nondiscrimination Act of 2008. This Plan shall be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act of 2008. The Plan will not use genetic information about you for underwriting purposes.

Health Care Reform Compliance.

- No Lifetime or Annual Limits. The Plan will not impose a lifetime or annual limit on the dollar value of essential health benefits provided under the Plan.

- No Rescission of Coverage. The Plan will not cancel or discontinue medical benefits under the Plan with a retroactive effect with respect to you or your covered dependents, except in the event of fraud, intentional misrepresentation, nonpayment of premiums, etc.

- No Cost Sharing on Recommended Preventive Care. The Plan will not require participant cost-sharing on recommended preventive care provided by in-network providers. Preventive care services covered in-network at 100% will be reviewed annually and updated prospectively to comply with recommendations of:

  - the United States Preventive Care Task Force;

  - the Advisory Committee on Immunization Practices that have been Adopted by the Director of the Centers for Disease Control and Prevention; and

  - the Comprehensive Guidelines Supported by the Health Resources and Services Administration.

- No Preexisting Condition Exclusions. No medical plan will impose a preexisting condition exclusion.

- Coverage of Clinical Trials. No medical plan will deny participation in an approved clinical trial for which a participant or dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or

procedures provided or performed in connection with participation in such an approved clinical trial. A participant or dependent participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial.

- Cost Sharing. The medical plans will comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the Affordable Care Act, indexed annually. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

Dental Option

As a participant in the Plan, you may elect to participate in dental coverage on a pre-tax basis.* The monthly costs and the description of your dental option are described in the annual or new employee enrollment packages, including any other underlying documents to the dental benefit. The Company will inform you during each open enrollment period concerning the cost of coverage and the type of coverage that is available.

*See the Domestic Partner information above regarding taxation.

Vision Option

As a participant in the Plan, you may elect to participate in vision coverage on a pre-tax basis.* The monthly costs and the description of your vision option are described in the annual or new employee enrollment packages, including any other underlying documents to the vision benefit. The Company will inform you again during each open enrollment period concerning the cost of coverage and the type of coverage that is available.

* See the Domestic Partner information above regarding taxation.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) provide valuable benefits designed to give you a tax-effective way to reimburse yourself on a tax-free basis for certain medical care and dependent care expenses. You can contribute up to $3,300 (for 2025, adjusted annually for inflation) on a pre-tax basis to a health care FSA to pay to cover eligible health care expenses not reimbursed by any medical, dental or vision care plan you are your eligible dependents may have. It is intended that the health care FSA is a limited Excepted Benefit under Code Section 9831 and as defined under HIPAA. Note that if you elect to enroll in the HDHP option and participate in an HSA, you will only be able to establish a limited purpose health care FSA which can only be used to reimburse dental and vision expenses. Claims from the previous year may be submitted during the claim run-out period - until March 31 of the current year. You can also contribute up to $5,000 on a pre-tax basis to a dependent care FSA to cover eligible dependent care expenses for children up to age 13 and certain older dependents who are disabled that are incurred so that you can work, or, if you are married, so you and your spouse can work (unless your spouse is a full-time student or is disabled). The amount of any applicable legal limits will be described in your annual open enrollment materials each year.

You may choose to utilize either or both the health care FSA and dependent care FSA. Note that employees enrolled in the high deductible health plan with a Health Savings Account are not eligible to participate in the health care FSA, but may participate in the Limited Purpose Flexible Spending Account. Due to current IRS tax regulations, SPs and GPs are not eligible to participate in FSAs.

Basic and Supplemental Life Insurance

There are several life insurance options available. In addition to the basic life insurance paid by the Company, you may elect to purchase (on an after-tax basis) supplemental life insurance coverage for yourself or coverage for your spouse and/or your dependent children. (You must elect additional coverage for yourself in order to insure your spouse and/or your dependent children). During each open enrollment period, the Company will provide you with more detailed information on its life insurance options as well as the cost of the supplemental coverage, which is subject to change each year.

Income Tax Considerations There are two tax considerations about which you should know:

- Imputed Income: The IRS requires that associates pay tax on imputed income related to the basic life insurance benefit. Per IRS guidelines, the imputed income amount is based on your age and the amount of coverage exceeding $50,000. Taxes on this imputed income will be withheld from your paycheck each pay period.

- Benefit Tax Treatment: Life Insurance benefits received are generally not to be included as gross income and are not taxable. The taxable portion of life insurance benefits would be interest earned (if applicable).

Basic and Supplemental Accidental Death and Dismemberment

In addition to the basic accidental death and dismemberment coverage paid by the Company, you may elect to purchase supplemental accidental death and dismemberment coverage (on an after-tax basis) for yourself or coverage for your spouse and/or dependent children. (You must elect additional coverage for yourself in order to insure your spouse and/or dependent children). During each open enrollment period, the Company will provide you with more detailed information on its accidental death and dismemberment options as well as the cost of the supplemental coverage, which is subject to change each year.

Employee Assistance Program

You and your dependents are automatically covered under the Employee Assistance Program. Information about the Employee Assistance Program is provided in a separate booklet. You may also obtain information by calling the number indicated in Appendix A.

Short-Term Disability

The Company recognizes the importance of protecting your income in the event of a disability. Information on the Short-Term Disability benefit is provided in a separate booklet. You may also obtain information by calling the number indicated in Appendix A.

Long-Term Disability

The Company recognizes the importance of protecting your income in the event of a long-term disability. Information on the Long-Term Disability benefits is provided in a separate booklet. You may also obtain information by calling the number indicated in Appendix A.

Wellness Programs

From time to time the Plan may offer wellness programs designed to promote the health and wellbeing of all employees as part of the medical benefit. These wellness programs may provide financial incentives to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health "coaching" and participate in disease management programs, provide on-line education tools, etc. These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Company money. Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness programs will be communicated to you separately as part of annual open enrollment materials or other communication. Additional information on the wellness programs is available by calling the numbers indicated in Appendix A.

Tobacco Cessation. Telephonic coaching sessions are available to participants and the participants spouse or domestic partner, if the spouse or domestic partner is enrolled in the medical plan. If the spouse or domestic partner is not enrolled, one the participant's children, age 18 or older, may participate if covered under the medical plan. Eligible members can schedule coaching sessions via the web, app or by calling the numbers indicated in Appendix A. Tobacco cessation coaching participants can receive up to two months supply of FDA-approved over-the-counter NRT via mail per wellness program year at no cost. Available forms include patches, lozenges and gum, in varying dosages.

CIRCUMSTANCES WHICH MAY AFFECT YOUR BENEFITS

Right to Amend or Terminate

Edward Jones retains the right to amend or terminate any of the benefits described in this document as it relates to any employee, dependent, beneficiary or subclass thereof in whole or in part at any time and for any reason. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits/coverages, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or copayments and/or any applicable maximums, (4) change the class(es) of employees and/or dependents covered by the Plan, and (5) change insurers, HMOs, third party administrators or other providers. In addition, any participating company may cease participation at any time with respect to its own employees. If the Plan or any component as described in this booklet is amended or terminated, you will be notified by the Company. Termination of a Plan will not adversely affect the payment of benefits to which you were entitled prior to the date of termination.

Modification of Elections to Meet Nondiscrimination Requirements

Federal law imposes rules to assure that the Plan does not discriminate in favor of officers and highly compensated employees of the Company. To avoid such discrimination, it may be necessary to limit or restrict your contributions or elections under the Plan. You will be notified if your contributions or elections must be modified.

No Contract of Employment

The Plan should not be considered a contract between the Company and any participant. Nothing in the Plan gives an employee a right to continued employment and the Company retains the right to discharge an employee at any time, except for the purpose of denying the employee any benefits for which he would otherwise be entitled.

Cessation of Participation

You should refer to the underlying benefits booklet for information on when coverage terminates. Generally, participation under the Plan (or any benefit option under the Plan, if applicable) will terminate automatically as of the first to occur of the following:

- the date on which the Plan terminates;
- medical, dental, vision, EAP, Basic Life, Basic AD&D, STD, LTD, Supplemental Life, Supplemental AD&D, FSA and coverage ends on the last day of the month (FAs, SPs, GPs) or the last day of the payroll period (HOAs, CSTs, TRs) in which you cease to meet the eligibility requirements. Other benefits will generally end on the date on which you cease to be an eligible employee;
- the date on which you fail to make a required contribution;
- the first day of any Plan Year in which you elect not to participate; or
- the date as of which you revoke your election of coverage.

You should refer to the underlying benefits booklet for information on when coverage terminates. Generally, participation of dependents under the Plan (or any benefit option under the Plan, if applicable) will terminate as of the first to occur of the following:

- the date as of which the eligible associate ceases to be covered by the Plan (or benefit option);
- the date on which the Plan terminates;
- medical, dental, vision, EAP, and FSA coverage ends of the last day of the month in which the dependent ceases to meet the applicable definition of dependent;
- the first day of any Plan Year in which dependent coverage is not elected;
- the date as of which the eligible employee fails to make a required contribution; or
- the date as of which the eligible employee revokes an election of dependent coverage.

Notwithstanding the foregoing, your coverage and the coverage of your dependents will terminate if you or your dependent(s) provide misleading or fraudulent information in order to obtain benefits under the Plan or you assist a third party in fraudulently obtaining benefits under the Plan. In such circumstances your coverage and the coverage of your dependent(s) will in accordance with the Affordable Care Act any guidance issued thereunder.

If your coverage terminates under the Plan you may be entitled for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as described below.

CONTINUATION COVERAGE

Authorized Leaves of Absence

The Company may continue coverage during certain periods of absence, such as absence by reason of sickness, disability, or other authorized leave of absence (including military leave), in accordance with its written personnel policies and practices and to the extent prescribed by law. If benefits are continued during a period of unpaid leave of absence, your contributions, if any, must be made in accordance with the Company's personnel policies and practices.

Leave Under Family Medical Leave Act (FMLA)

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for a newborn or adopted child, you will be able to continue your health coverage under the Plan, provided you pay any applicable contribution(s). If you drop your health coverage during the leave, you will not have any coverage for yourself and/or your eligible dependents. Once you return from your leave, you can elect to have your health coverage reinstated on the date you return to work, assuming you pay any contributions required for the coverage. Other coverages may also be reinstated. You will receive more information about your choices if you take an FMLA leave.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that has several provisions designed to protect you and your eligible dependents against a sudden loss of health care coverage if you have a qualifying event that would cause the loss of your health care coverage under the Plan. The following information outlines the continuation of coverage available under COBRA. This COBRA section applies only to the medical, prescription drug, dental, vision, employee assistance program (EAP), health care FSA and Limited Purpose Flexible Spending Account options described in this document.

General Explanation of COBRA Continuation Coverage. COBRA requires most employers who sponsor group health care plans to provide a temporary extension of health care coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called COBRA continuation coverage.

Individuals who are eligible for COBRA continuation coverage are called *qualified beneficiaries*. The events that entitle qualified beneficiaries to coverage are called *qualifying events*. In addition, a child born to, adopted by, or placed for adoption with the covered employee during the COBRA continuation coverage period will be a qualified beneficiary for COBRA purposes. To be a qualified beneficiary for a specific type of health coverage (*i.e.*, medical, dental, or employee assistance program), you must have had that particular coverage under the Plan on the day before a qualifying event occurs.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. You can learn more about these options at www.healthcare.gov.

Who Must Provide Notice When Coverage is Lost. When a qualifying event occurs, you and the Company have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or a covered dependent must notify the Plan Administrator in the Human Resources Department in writing within 60 days of the date of the qualifying event or the date that coverage ends. Your notice should include the name of the individual who is losing coverage, the type of qualifying event and the date of the qualifying event. Please note, if the qualifying event is divorce or legal separation, you will also need to provide a copy of the page of the divorce decree that indicates the date of the divorce. The Company will notify the Plan Administrator if the event is death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

When the Plan Administrator is notified of a qualifying event, the Plan Administrator or its designee will send you and/or your dependents a written explanation of the right to elect COBRA continuation coverage, so it is important to ensure that we have current addresses for you and your dependents who reside at a different location, if any. You then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which your existing coverage would end to notify the Plan Administrator of your election. If you and/or a dependent do not respond in writing within the time limit, the right to elect to COBRA continuation coverage will be lost and will not be reinstated.

The chart below summarizes who is eligible for COBRA continuation coverage under COBRA, under what circumstances, and for how long. Important Note: Coverage under the health care FSA will not continue beyond the Plan Year in which the qualifying event occurs.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment Termination of employment for reasons other than gross misconduct	18 months* 18 months*
Covered Spouse of an Employee	Death of employee Divorce or legal separation from employee Employee becomes entitled to Medicare benefits Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 18 months* 18 months*
Covered Child of an Employee	Death of employee Divorce or legal separation of employee and spouse Employee becomes entitled to Medicare benefits Failure of child to qualify as a dependent under the Plan Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 36 months 18 months* 18 months*

* The 18-month COBRA continuation coverage period will be extended to 29 months for all qualified beneficiaries if any qualified beneficiary is disabled under the Social Security laws at any time during the first 60 days of COBRA continuation coverage. To qualify for this extension, the qualified beneficiary must notify the Plan Administrator and provide proof that he or she is disabled under the Social Security laws before the expiration of the 18-month period and within 60 days of notification of eligibility for Social Security disability benefits. The Plan Administrator is permitted to charge a higher premium for COBRA continuation coverage during the 19th through 29th months. If the employee finds that he or she is no longer disabled, he or she must notify the Plan Administrator within 30 days of such a determination.

The 18, 29, or 36 months of COBRA continuation coverage begin on the date that coverage would originally end.

If You Elect to Continue Coverage. Each qualified beneficiary who is eligible to elect COBRA continuation coverage may make a separate election to continue coverage, or one qualified beneficiary may make an election that covers some or all of the other qualified beneficiaries.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or any higher charge that may be permitted by law, such as during the extended coverage on account of disability). The total premium includes both the Company's contribution and any contribution that an active participant would be required to make under the Plan for the same coverage. The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for each month after your election are due by the 1st day of the month and must be paid not later than the last day of that month. Premium rates will change periodically for all qualified beneficiaries if costs to the Company change. COBRA continuation coverage will be identical to the coverage provided similarly situated employees and/or dependents. Your health care coverage will continue to be provided by the insurer, HMO, or other provider that is providing benefits to you on the date of the qualifying event (subject to any residency requirements that may apply). You will have an opportunity to change coverage options during the annual open enrollment period. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

Coverage You May Elect. You may elect to continue medical coverage only, dental coverage only, vision only, EAP coverage only, health care FSA coverage only, or any combination of these coverages. You may elect to continue only those coverages that were in effect for you on the date of your qualifying event. Since life insurance, accidental death and dismemberment insurance, long-term disability insurance, short-term disability insurance and dependent care are not health care benefits protected by COBRA, you may not elect COBRA continuation coverage of those benefits under the Plan. You may, however, have conversion rights or portability rights under certain of these insurance policies.

Coverage for Eligible Dependents. If you elect COBRA continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of coverage until the next annual open enrollment period. At that time, they may change their coverage if they wish. However, if you continue some, but not all, of the coverages to which you are entitled, or if you decide not to continue your coverage at all, each dependent may make an independent coverage selection.

Changes to COBRA Continuation Coverage. Qualified beneficiaries have the same opportunities to change coverage as active employees during each annual open enrollment period. During each annual open enrollment period, you may elect different coverage or add or delete dependents in the same manner as an active employee.

If You Have Region-Specific Coverage. If you are enrolled in a region-specific coverage option (such as an HMO) on the day before your qualifying event occurs, you may elect COBRA continuation coverage. However, you must remain in that coverage until the next annual open enrollment period, at which time you may change coverage if you so wish. If you move out of the service area during your period of COBRA continuation coverage, you may be able to elect alternate coverage.

Special Rule for Health Care FSA. In the case of the health care FSA, special rules apply. First, COBRA continuation coverage will be offered only if your reimbursements for the year under the health care FSA at the time coverage is lost do not exceed the total contributions to the health care FSA for the year. Second, if COBRA continuation coverage is offered under the health care FSA, it will only be offered for the balance of the plan year in which coverage is lost and will not be offered for subsequent years.

Please be aware that any contributions you make under the health care FSA pursuant to COBRA will be made on an after-tax basis at a rate of 102% of the amount available for reimbursement. Therefore, the chief advantage of participating in the account – that is, the tax savings attributable to payment of qualifying expenses with pre-tax dollars – will not be available to you.

When COBRA Benefits End. Generally, COBRA continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA continuation coverage will end immediately if:

- the person whose coverage is being continued fails to pay the premium on time;
- the person whose coverage is being continued becomes, after the date of the election of COBRA continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation that does not apply to (or is satisfied by) the person under applicable provisions of federal law);
- in the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the disabled person is no longer disabled under the Social Security laws; or
- the Company no longer maintains a group health plan covering any employee.

Second Qualifying Event. An 18-month period of COBRA continuation coverage may be extended if a second qualifying event occurs during the initial 18-month COBRA coverage period. However, no one may extend coverage for more than 36 months from the occurrence of the first qualifying event. For example, if your employment ends and you get divorced during the initial 18-month continuation period, your dependents (but not you) may extend coverage for up to 36 months from the date your employment ended. If the covered employee becomes entitled to Medicare benefits and during the subsequent 18-month period loses coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than the employee will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement, subject to the rules regarding earlier termination of COBRA coverage. You or your dependent must notify the COBRA administrator of a second qualifying event as noted in Appendix A.

California COBRA. If you live in California and are covered by a Health Maintenance Organization (such as Kaiser), you and your spouse may be eligible to continue group coverage for a limited period of time beyond the date your COBRA coverage ends. You will be notified of your right to this coverage if you are eligible. If you meet the criteria described in this notice, you may continue your coverage as if your COBRA coverage had remained in effect.

Note: If you are eligible for Medicare, do not delay enrollment even if you elect COBRA. COBRA pays secondary to Medicare regardless of Medicare enrollment. This means you will experience higher claim costs and potential penalties if you delay Medicare enrollment. Contact Medicare.gov or a Medicare expert for additional information.

If you are enrolling or already enrolled in COBRA coverage and have any questions, please contact the Company (see Appendix A).

Continuation Coverage Under Long Service Plan

Associates who are no longer eligible to participate in the Medical Plan due to termination of employment or due to a reduction in hours and who meet the "Rule of 70" may be eligible to apply for an extension of medical coverage beyond their COBRA continuation period. This extension is called the Long Service Plan.

Associates are eligible for this extension of coverage if:

- they are at least 50 years old at the time of retirement, termination, or reduction in hours and
- their age at the time of retirement, termination, or reduction in hours, added to their active working years of service with Edward Jones equals at least 70, and

- The termination reason in the human capital management system or any subsequent human resources database is one of the following: V - Retirement, Disabled, IV - 12 months inactivity, IV - Job Elimination Project Term Completion, V – Voluntary Separation Program, V - Dissatisfied with Job, V - End of Short-term Assignment, V - Military Commitment, , V - Personal Financial Reasons, ,V -Pursue Opportunity Outside Industry, V - Resigned in Lieu of Termination or V - Return to School.

Eligible associates must enroll in and exhaust the 18-month COBRA period in order to apply for the Long Service Plan. The Long Service Plan would begin the day after COBRA coverage ends. Participants of the Long Service plan are only eligible to participate in the Gold Plan. If at the time of transition from COBRA the participant is on the Silver plan s/he must move to the Gold Plan and will only be eligible for that plan until exhausting Long Service Plan benefits. If the associate is eligible for Medicare (but otherwise meets age and length of service requirements) when he or she retires/terminates from Edward Jones, his/her enrolled dependents will be eligible for the Long Service Plan for a period of time equal to the associate's time in service at Edward Jones, or until eligible for Medicare (whichever occurs first).

The Long Service Plan benefits may not be the same coverage level that the associate had while an active associate. The Long Service Plan extends medical coverage only, not Dental, Life, Vision, or any other non-medical benefits offered through the Plan.

Associates pay 102% of the cost of coverage for the Long Service Plan. Coverage for associates under the Long Service Plan ends when the former associate turns age 65 or becomes eligible for Medicare, whichever occurs first.

Spouses or Domestic Partners who are under age 65 at the time associate coverage ends will be permitted to continue coverage on an individual basis until the earlier of: the date the spouse turns age 65; the date the spouse is eligible for Medicare; or the date equal to the former associate's length of service with Edward Jones; whichever occurs first. Eligible dependent children may continue under the plan until reaching maximum age limits. If the child is disabled and continues eligibility beyond the usual age limits due to a qualifying disability, he/she may continue on the plan until age 65, ceases to be an eligible dependent, ceases his/her disability or until eligible for Medicare, whichever occurs first. For more information about the Long Service Plan, please contact the Edward Jones Benefits Department.

If you are eligible for Long Service Plan continuation coverage, you may elect to cover dependents acquired after your date of eligibility provided the COBRA administrator is notified within the prescribed time period. In general, the newly acquired dependents will not have an independent right to COBRA continuation coverage, except for newborns who are considered Qualified Beneficiaries. Failure to notify the administrator within the prescribed time will result in a waiver of the right to elect LSP for the newly acquired dependents. To be eligible for this extension, you or your dependents must notify the COBRA administrator within 60 days of the second event.

Continuation Coverage During Military Service

Employees who leave employment for military leave will have the right to continue employer-provided health coverage for themselves and their dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”). Contact the Plan Administrator for more information on how USERRA applies to you and your dependents.

ADMINISTRATION OF THE PLAN

Within the meaning of ERISA, the Plan Administrator is the Benefits Administrative Committee. The name, business address, and business telephone number are provided in the General Information section.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issue of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties including to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

Reasonable plan expenses may be paid from plan assets.

UNCLAIMED FUNDS

As a condition of entitlement to a benefit under the Plan (self-funded options), participants and beneficiaries must keep the Plan informed of their current mailing address and other relevant contact information. If the Plan is unable to locate any individual otherwise entitled to a benefit payment after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator or its delegate), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits.

In addition, as a further condition to any benefit entitlement under the Plan, any person claiming the benefit must present for payment the check evidencing such benefit within one year of the date of issue. Where a check is not received or is lost, it is the participant or beneficiary's responsibility to notify the Plan Administrator within one year of the date of service, or for disability, the date the check was generated, and request that a new check be issued. If any check for a benefit payable under the Plan is not presented for payment within one year of the date of issue of the check, the Plan shall have no liability for the benefit payment, and the amount of the check shall be deemed forfeiture. Where it is administratively feasible, forfeited funds revert back to the respective Plan.

CLAIM PROCEDURES

The underlying booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply. If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the Plan Administrator immediately.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level. Refer to Appendix A for details.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Appendix A. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the "General Information" section below. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Claims Not Involving Health Benefits

In the case of a claim not involving health benefits (e.g., life insurance, accidental death and dismemberment, long-term disability, and short-term disability), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

Time Periods for Responding to Initial Claims. If you bring a claim for benefits under the Plan, the Claims Administrator will respond to you within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims other than claims involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim. If the Claims Administrator determines that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of an additional 30-day extension.

Notice and Information Contained in Notice Denying Initial Claim. If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal); and
- Special Rules Applicable in the Case of any Claim Involving Disability Benefits – Any notice of adverse determination will include:
    - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request;
    - if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    - a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan; and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
    - Note that an adverse benefit determination shall include rescissions of disability coverage, regardless of whether the rescission had an adverse effect on any particular benefit, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Appealing a Denied Claim for Benefits. If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal. Prior to issuing a denial of an appeal of a claim involving disability, the Appeals Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and/or with any new or additional rationales for denying the claim, as soon as possible and sufficiently in advance of the date the appeal is to be considered to give you a reasonable opportunity to respond prior to the date the appeal will be considered.

Time Periods for Responding to Appealed Claims. If you bring a claim for benefits under the Plan, the Appeals Administrator will respond to you within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If the Appeals Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Appeals Administrator will notify you within the initial 60-day period that the Appeals Administrator needs up to an additional 60 days (45 days in the case of a claim involving disability benefits) to review your claim.

Notice and Information Contained in Notice Denying Appeal. If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits, and for any claims involving disability benefits, must also include a description of any contractual limitations period that applies to the claimant's right to bring an action and the calendar date on which the contractual limitations period expires for the claim; and
- Special Rules Applicable in the Case of any Claim Involving Disability Benefits - Any notice of adverse determination will include:
    - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request;
    - if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
    - a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan; and
    - a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Claims Involving Health Benefits

In the case of a claim involving health benefits (e.g., medical, dental, vision, prescription drug, and employee assistance program), initial claims for benefits under the Plan shall be made by you in writing to the Claims Administrator.

Types of Claims. There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

- Pre-Service Claim. A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
- Post-Service Claim. A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
- Urgent Care Claim. An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- Concurrent Care Review Claim. A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Claims. If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:

- Pre-Service Claim. In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Post-Service Claim. In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Urgent Care Claim. In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this

notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- Concurrent Care Review Claim. If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Claim. If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appealing a Denied Claim for Benefits. If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims. If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

- Pre-Service Claim. In the case of an appeal of a denied pre-service claim under a procedure that provides one level of review, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal. If the procedure provides two levels of review, the Appeals Administrator shall respond with respect to each level of review within 15 days after receipt of the appeal.

- Post-Service Claim. In the case of an appeal of a denied post-service claim under a procedure that provides one level of review, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal. If the procedure provides two levels of review, the Appeals Administrator shall respond with respect to each level of review within 30 days after receipt of the appeal.

- Urgent Care Claim. In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.

- Concurrent Care Review Claim. In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal. If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

Notwithstanding the foregoing, the Plan will comply with the applicable requirements of the Affordable Care Act relative to all claims for medical benefits (unless the benefit is an "excepted benefit" to which the Affordable Care Act does not apply, as determined by the Claims or Appeals Administrator), including but not limited to the following:

- Adverse Benefit Determination - The definition of adverse benefit determination shall include rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit;

- Right to Review Claim File – You shall be given the right to review your claim file, including access to and copies of documents, records and other information relevant to their claim;

- Opportunity to Present Evidence and Testimony – You shall be given the opportunity to present evidence and testimony as part of the appeals process. The terms “evidence” and “testimony” shall be interpreted in accordance with Department of Labor guidance;

- Disclosure of New Rationale and Opportunity to Respond - In the event the Plan (or the entity hearing an internal appeal of an adverse benefits determination on behalf of the Plan, such as the Appeals Administrator) considers, relies upon or generates new or additional evidence in connection with the claim, or is considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Plan will advise you in advance of the determination of the new evidence or rationale being considered, and shall allow you no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event you will be provided no less than two (2) days to respond to the new evidence or rationale; and

- No Conflict of Interest - To the extent Plan personnel are involved in the claims process, the Plan will not consider in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any claimant, whether or not such individual is likely to support the denial of benefits to a claimant.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

External Review. You may be eligible to file a request for external review with the Plan of an adverse benefit determination in accordance with the applicable requirements of the Affordable Care Act. The external review is available if the adverse benefit determinations based upon rescissions of coverage and claim denials that involve medical judgment.

You or your representative may request an external review by sending a written request to the address set out in the claims administrator's decision letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the decision letter. A written request must be made within four months after the date you received the claims administrator's decision.

An external review request should include all of the following:

- A specific request for an external review
- The covered person's name, address, and insurance ID number
- Your designated representative's name and address, when applicable
- The service that was denied, and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by the claims administrator or any of its affiliates. There are two types of external reviews available:

- A standard external review, and
- An expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- A preliminary review by the claims administrator of the request
- A referral of the request by the claims administrator to the IRO, and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, the claims administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided
- Has exhausted the applicable internal appeals process, and
- Has provided all the information and forms required so that the claims administrator may process the request.

After the preliminary review is completed, the claims administrator will issue a notification in writing to you. If the request is eligible for external review, it will be forwarded to an IRO to conduct the review.

The claims administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of your eligibility and acceptance for external review. You may submit in writing to the IRO within 10 business days following the date of receipt of this notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

The claims administrator will provide to the assigned IRO the documents and information considered in making the claim determination. The documents include:

- All relevant medical records
- All other documents relied upon, and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and the claims administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide written notice of its decision within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of its decision to you and the claims administrator and it will include the clinical basis for the determination.

Upon receipt of a decision reversing the claims administrator's determination, the plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the plan, and any applicable law regarding plan remedies. If the decision is that payment or referral will not be made, the plan will not be obligated to provide benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal, or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the claims administrator will determine whether the individual meets both of the following:

- Is or was covered under the plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that the claims administrator may process the request.

After the review is complete, the claims administrator will immediately send a notice in writing to you. If the request is eligible for expedited external review, the claims administrator will assign an IRO in the same manner used to assign standard external reviews. The claims administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the claims administrator. The IRO will provide notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and the claims administrator.

Exhaustion of Claims and Appeals Procedures.

The following provision applies to the extent the underlying documents for a benefit do not dictate a statute of limitation to bring a claim under the Plan. A claim or action (i) to recover benefits allegedly due under the Plan or by reason of any law, (ii) to enforce rights under the Plan, (iii) to clarify rights to future benefits under the Plan, or (iv) that relates to the Plan and seeks a remedy, ruling or judgment of any kind against the Plan or a Plan fiduciary or party in interest (collectively, a "Judicial Claim"), may not be commenced in any court or forum until after the claimant has exhausted the Plan's claims and appeals procedures, including, for these purposes, any voluntary appeal right and/or independent external review rights (an "Administrative Claim"). A claimant must raise every argument and/or produce all evidence the claimant believes supports the claim or action in the Administrative Claim and shall be deemed to have waived any argument and/or the right to produce any evidence not submitted to the Administrator or its delegate as part of the Administrative Claim. Any Judicial Claim must be commenced in the appropriate court or forum no later than 24 months from the earliest of (A) the date the first benefits were paid or allegedly due; (B) the date the Administrator or its delegate first denied the claimant's request; or (C) the first date the claimant knew or should have known the principal facts on which such claim or action is based; provided, however, that, if the claimant commences an Administrative Claim before the expiration of such 24 month period, the period for commencing a Judicial Claim shall expire on the later of the end of the 24 month period and the date that is 3 months after final denial of the claimant's Administrative Claim, such that the claimant has exhausted the Plan's claims and appeals procedures. Any claim or action that is commenced, filed or raised, whether a Judicial Claim or an Administrative Claim, after expiration of such 24-month period (or, if applicable, expiration of the 3-month period following exhaustion of the Plan's claims and appeals procedures) shall be time-barred. Filing or commencing a Judicial Claim before the claimant exhausts the Administrative Claim requirements shall not toll the 24-month limitations period (or, if applicable, the 3-month limitations period).

STATEMENT OF ERISA RIGHTS

As a participant in Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INDEMNIFICATION

The Company will indemnify each officer, director or employee of the Company for all expenses (other than amounts paid in settlement to which the Company does not consent) reasonably incurred by him or her in connection with any action to which he or she may be a party by reason of his or her performance of administrative functions and duties under the Plan, except in relation to matters as to which he or she is adjudged in such action to be personally guilty of gross negligence or willful misconduct in the performance of his or her duties. The foregoing rights to indemnification are in addition to such other rights as the individual may enjoy as a matter of law or by reason of insurance coverage of any kind but shall not extend to costs, expenses and/or liabilities otherwise covered by insurance or that would be so covered by any insurance then in force if such insurance contained a waiver of subrogation. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which the individual may be entitled pursuant to the Company's by-laws.

PRIVACY OF HEALTH INFORMATION

The receipt, use and disclosure of protected health information by the medical benefit, dental benefit, vision benefit, employee assistance program and health care FSA portions of the Plan is governed by regulations issued under the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your consent or authorization. In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. For more information about the privacy of your protected health information under HIPAA, see the Plan's Notice of Privacy Practices, which has been distributed to you and for which a copy may be requested by contacting the Plan Administrator.

DEPARTMENT OF LABOR ONLINE SECURITY TIPS

You can reduce the risk of fraud and loss to your data and health information by following these basic rules:

- **Set up and routinely monitor your online account**
  - Regularly check your claims online to reduce the risk of fraudulent account access.
  - Failing to register for an online account may enable cybercriminals to assume your online identity.
- **Use strong and unique passwords**
  - Do not use dictionary words.
  - Use letters (both upper and lower case), numbers, and special characters.
  - Do not use letters and numbers in sequence (no "abc," "567," etc.).
  - Use 14 or more characters.
  - Do not write passwords down.
  - Consider using a secure password manager to help create and track passwords.
  - Change passwords every 120 days, of it there's a security breach.
  - Do not share, reuse, or repeat passwords.
- **Use multi-factor authentication**
  - Multi-factor authentication (also called two-factor authentication) requires a second credential to verify your identity (for example, entering a code sent in real-time by text message or emails).
- **Keep personal contact information current**
  - Update your contact information when it changes, so you can be reached if there is a problem.
  - Select multiple communication options.
- **Close or delete unused accounts**
  - The smaller your on-line presence, the more secure your information. Close unused accounts to minimize your vulnerability.
  - Sign up for account activity notifications.
- **Be wary of free Wi-Fi**
  - Free Wi-Fi networks, such as the public Wi-Fi available at airports, hotels, or coffee shops pose security risks that may give criminals access to your personal information.
  - A better option is to use your cellphone or your home network.
- **Be aware of phishing attacks**
  - Phishing attacks aim to trick you into sharing your passwords, account numbers, and sensitive information, and gain access to your accounts. A phishing message may look like it comes from a trusted organization, to lure you to click on a dangerous link or pass along confidential information.

- Common warning signs of phishing attacks include:
  - A text message or email that you did not expect or that comes from a person or service you do not know or use.
  - Spelling errors or poor grammar.
  - Mismatched links (a seemingly legitimate link sends you to an unexpected address). Often, but not always, you can spot this by hovering your mouse over the link without clicking on it, so that your browser displays the actual destination.
  - Shortened or odd links or addresses.
  - An email request for your account number or personal information (legitimate providers should never send you emails or texts asking for your password, account number, personal information, or answers to security questions).
  - Offers or messages that seem too good to be true, express great urgency, or are aggressive and scary.
  - Strange or mismatched sender addresses.
  - Anything else that makes you feel uneasy.

- **Use antivirus software and keep apps and software current.**
  - Make sure that you have trustworthy antivirus software installed and updated to protect your computers and mobile devices from viruses and malware. Keep all your software up to date with the latest patches and upgrades. Many vendors offer automatic updates.
- **Know how to report identity theft and cybersecurity incidents.**
  - The FBI and the Department of Homeland Security have set up valuable sites for reporting cybersecurity incidents:
    - **https://www.fbi.gov/file-repository/cyber-incident-reporting-united-message-final.pdf/view**
    - **https://www.cisa.gov/reporting-cyber-incidents**

THIRD PARTY LIABILITY

The Plan has a right to subrogation and reimbursement. Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible.

The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree to cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
- providing any relevant information requested by the Plan;
- signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;

- responding to requests for information about any accident or injuries;

- making court appearances;

- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and

- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.

- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

- The Plan and all Claims Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your dependent's behalf that were:

- made in error;

- due to a mistake in fact;

- advanced during the time period of meeting the calendar year Deductible; or

- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year. Benefits paid because you or your dependent misrepresented facts are also subject to recovery.

If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or

- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover benefits it has advanced by:

- submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the Plan; and

- conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the Plan.

RECOUPMENT

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plan under the "Third Party Liability" section above. The Plan, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider (whether in-network or out-of-network), if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan or a waiver of this provision. Additionally, while a covered person, under ERISA, may appoint an authorized representative to file a claim for benefits or appeal a denied claim for benefits on his or her behalf in accordance with the relevant provisions under ERISA, no such appointment may be made to an out-of-network provider and no such appointment to any provider (whether in-network or out-of-network) shall render any provider, or cause such provider to be, a beneficiary under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

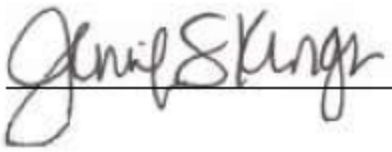
If a qualified medical child support order (QMCSO) issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- name and last known address of each child to be covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Plan's procedures for determining if the order is qualified. If the order is qualified, you may cover your children under the Plan. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

The Employer has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

Edward D. Jones & Co., L.P

By: 

Name: Jennifer Kingston

Title: Benefits Administrative Committee Chairperson

Date: June 17, 2025

APPENDIX A
CONTACT INFORMATION FOR YOUR BENEFIT OPTIONS

TYPE OF BENEFIT/PROVIDER	NAME AND ADDRESS OF CLAIMS ADMINISTRATOR	FUNDING
Medical (including Prescription Drug)		
Medical Plan		
• Medical and Behavioral Health Benefits	Anthem Blue Cross Blue Shield P.O. Box 54159 Los Angeles, CA 90054-0159 Phone: (800) 359-0640	Self-Insured
• Prescription Drugs	Express-Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417 Phone: (201) 269-3400	Self-Insured
• Wellness Program	Personify Health 75 Fountain Street Providence, RI 02902 Phone: (833) 880-4209	
• HMSA	HMSA Member Advocacy & Appeals P.O. Box 1958 Honolulu, HI 96805-1958 Fax: 808-952-7546 or 808-948-8206 on Oahu	Insured
• Surgical Center of Excellence	Lantern Attn: Claims Processing 2100 Ross Ave. #1900 Dallas, TX 75201 Phone: (888) 965-4011	Self-Insured
Dental	Delta Dental of Missouri P.O. Box 8690 St. Louis, MO 63126 Phone: (800) 3358266	Self-Insured
Vision	Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 1-800-877-7195	Self-Insured

TYPE OF BENEFIT/PROVIDER	NAME AND ADDRESS OF CLAIMS ADMINISTRATOR	FUNDING
Flexible Spending Accounts • Health Care Flexible Spending Account • Limited Purpose Health Care Flexible Spending Account • Dependent Care Flexible Spending Account	HealthEquity 15 Scenic Pointe Dr., Ste 100 Draper, UT 84020 (844) 281-0433	Self-Insured
Employee Assistance Program	Headspace 2417 Michigan Avenue Santa Monica, CA 90404 (855) 420-0734	Self-Insured
Long-Term Disability	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-711-1375	Insured
Short-Term Disability	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-711-1375	Self-Insured
Basic and Supplemental Life Insurance	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-711-1375	Insured
Basic and Supplemental Accidental Death & Dismemberment	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505 1-833-711-1375	Insured
Supplemental Individual Disability Insurance	UNUM P.O Box 100158 Columbia, SC. 29202-3158 1-888-226-7959	Insured
COBRA Administrator	TriStar 16401 Swingley Ridge Road Suite 250 Chesterfield, MO 63017 (800)727-0182	

Benefit Questions	
If you cannot find answers to your questions in this booklet or want more information about the Plan	**HRHELP@edwardjones.com or by calling 1-800-440-3060 or 314-515-1006**